

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-030023

7402

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

DO NOT WRITE
ON THIS STUB

AMENDED

FILED JUL 25 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (if outside corporate limits, give TOWNSHIP only)

OR
TOWN

ST. LOUIS, MO.

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MO

b. COUNTY

admission)

c. CITY
OR
TOWN

ST. LOUIS, MO

Inside Limits

Yes ☐ No ☐

c. FULL NAME OF (if NOT in hospital, give location)

HOSPITAL OR
INSTITUTION

ST. LOUIS CITY HOSP. #1.

Inside Limits

Yes ☐ No ☐d. STREET
ADDRESS(If outside, give location)
1020 N. 9th ST.

Reside on Farm

Yes ☐ No ☐

3. NAME OF DECEASED

(Type or print)

First
ROBIN BABY GIRL

Middle

Last
HEARD4. DATE
OF
DEATH

Month

Day

Year

7/6/63

5. SEX

FEMALE

6. COLOR OR RACE

NEGRO

7. Married ☐Never Married ☒Widowed ☐Divorced ☐

8. DATE OF BIRTH

7/1/63

9. AGE (last birthday)

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

NONE

10b. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (City and state or country)

ST. LOUIS, MO

12. CITIZEN OF WHAT COUNTRY

U.S.A

13a. FATHER'S NAME

UNKNOWN

13b. MOTHER'S MAIDEN NAME

JEWELYN HEARD

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

NO

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

ST. LOUIS CITY HOSP. #1.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Presumably

DUE TO (b)

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (c)

776X

INTERVAL BETWEEN
ONSET AND DEATHPART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURY

Hour

Month, Day, Year

a.m.

p.m.

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

7/1/63

7/6/63

7/6/63

21. I attended the deceased from 7/1/63 3:00 P. to 7/6/63 and last saw her alive on 7/6/63
Death occurred at m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Anne E. Bannon, M.D.

22b. ADDRESS

1515 LAFAYETTE AVE.

22c. DATE SIGNED

7/6/63

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

7-31-63

23c. NAME OF CEMETERY OR CREMATORY

Anatomical Board

23d. LOCATION (City, town, or county)

St. Louis, Mo.

24. FUNERAL DIRECTOR

ADDRESS

Ogden 4106 Manchester

25. DATE RECD. BY LOCAL REG.

JUL 18 1963

26. REGISTRAR'S SIGNATURE

Rosal Smith, M.D.

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

ANNE E. BANNON, M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT; he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.